VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
http://www.dlp.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

September 11, 2014

Ms. Melissa Greason, Administrator
Washington Elms
126 Elm Street
Bennington, VT 05201-2232

Dear Ms. Greason

The Division of Licensing and Protection completed the onsite re-licensing survey in conjunction with a complaint investigation at your facility on **August 26, 2014**. The purpose of the survey was to determine if your facility was in compliance with Vermont Residential Care Home Regulations. The survey statement is enclosed. This survey found the most serious deficiency in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy. You must submit a plan of correction. Please write/type the Plan of Correction in the space provided to the right. A completion date for each plan of correction must be indicated in the far right hand column. Attach additional pages if necessary.

Please sign, date, and indicate your title on the bottom of the first page of the report and return this report to this office no later than **September 24, 2014**.

Plan of Correction (POC)

Your POC must contain the following:

- What action you will take to correct the deficiency;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and,
- How the corrective actions will be monitored so the deficient practice does not recur.
- The dates corrective action will be completed.

If you disagree with the existence or accuracy of a deficiency, please provide comments in the space provided beneath the deficiency statement.

You may also request an informal review of all or part of the contents of the notice at any time prior to **September 24, 2014** by calling Frances Keeler, RN, MSN, DBA, Assistant Division Director, or Clayton Clark, Division Director at 871-3317. If you are not satisfied with the outcome of the informal review with the Division, you may request a review by the Commissioner of Disabilities, Aging and Independent Living. To request a review with the Commissioner, call (802) 871-3350.

The Department is authorized to impose sanctions for failure to correct a deficiency and/or failure to provide proof of correction by the specified Correction Date. Depending on the nature of the violations, the following sanctions may be imposed: administrative penalties of up to $10.00 per resident or $100.00, whichever is greater, for each day the violation remains uncorrected; suspension, revocation or modification of an existing license; refusal to renew a license; suspension of admission or transfer of residents to an alternative placement; injunctive relief to enjoin any act or omission; and the appointment of a receiver for a facility. If you feel strict compliance with the law or regulations would impose a substantial hardship, you may apply to the Department for a variance as stated under Section III of the Residential Care Home Licensing Regulations. You must do so prior to **September 24, 2014**.

Appeals

As noted above, you may seek an informal review from Frances Keeler, RN, MSN, DBA, Assistant Division Director, or a Commissioner's review of this decision. In addition, you have a right to request a fair hearing with the Human Services Board. Decisions by the Department of Disabilities, Aging and Independent Living can be appealed to the Human Services Board pursuant to 3 V.S.A. §3091. The request for a fair hearing before the Human Services Board must be made within thirty (30) days of your receipt of the notice of this decision, and can be made by writing to the Board at 14-16 Baldwin Street, Montpelier, VT 05633-4302. You have a right to appear before the Board and to present witnesses and other evidence with regard to the case. You also have a right to be represented by an attorney at the Human Services Board fair hearing.

Please contact me at 871-3317 if you have any questions.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PC:jl

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October 8, 2014

Ms. Melissa Greason, Administrator
Washington Elms
126 Elm Street
Bennington, VT 05201-2232

Dear Ms. Greason:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 26, 2014.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PC:jl

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Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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WASHINGTON ELMS	126 ELM STREET BENNINGTON, VT 05201

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R100	Initial Comments: An onsite re-licensing survey was conducted by the Division of Licensing and Protection on 8/25 and 8/26/14, in conjunction with a complaint investigation. There were regulatory findings.	R100		
R145 SS=B	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to oversee the development of written plans of care for 3 of 6 residents in the sample, Residents #1, #2 and #6. Findings include: 1. Review of Resident #1 medical record on 8/26/14 at 2:30PM, presented with a care plan that was last reviewed 4/19/13 and per interview with the Registered Nurse (RN) manager, at the time of discovery, the care plan did not reflect Resident #1 and his/her current status prior to hospitalization. An annual assessment was completed by the RN in May of 2014 and h/she stated that the care plan had not been reviewed at that time. 2. Review of Resident #2 medical record on 8/26/14 at 2:40PM, presented with a care plan that was last reviewed 4/19/13 and per interview	R145	See Attached	

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: owner/Administrator (X6) DATE

R145, R155, R160, R162, R165, R179, R181, R192, R208, R224, R240, R246, R247, R259, R266, + R269 plans of correction accepted 10/7/14 BBortell RN/PMC

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R145	Continued From page 1 with the RN manager, at the time of discovery, the care plan did not reflect Resident #2 and his/her current status. An annual comprehensive assessment had been completed by the RN and h/she stated that the care plan had not been reviewed at that time. H/she also confirmed that the care plan in the record contained outdated information that needed to be removed. 3. Review of Resident #6 medical record on 8/26/14 at 11:15AM, presented with a care plan that was last reviewed 4/19/13 and not revised. A significant change assessment was completed 11/14/13 and per interview with RN manager, h/she stated that the care plan did not reflect the current status of the resident. H/she also confirmed that the care plan in the record contained outdated information that needed to be removed.	R145	See Attached	
R155 SS=G	V. RESIDENT CARE AND HOME SERVICES 5.9.c. (12) Assume responsibility for staff performance in the administration of or assistance with resident medication in accordance with the home's policies. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the nurse failed to assure that staff performance in administration of medications is in accordance with the home's policies, and professional standards, for 4 of the Residents, #1, #6, #7 and #8.	R155	See Attached	

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R155	Continued From page 2	R155	See Attached	

1. Resident #1 was administered medications that were for another resident on 8/19/14 during the evening scheduled 5:30PM medication administration time. The medications included Clonazapine 200mg and Risperidone 2mg. Resident #1 did not have an order for psychotropic medications. His/her diagnoses include: Developmental Delay, Hypertension, Diabetes Type 2 and Hypercholesterolemia. During interview with medication delegated caregiver at 6:15PM on 8/25/14, h/she stated that it got very chaotic and it was noisy and there was a lot of confusion. H/she stated that "a whole bunch of residents" came into the kitchen at the same time to get there medications and h/she just started giving them. H/she stated that they gave the medications and then when they looked into the medicine cup for the resident that was next, h/she realized that the wrong medication had been given to Resident #1 and h/she gor immediate emergency assistance. H/she also realized that the label should have been checked and h/she should not have relied on what the pills looked like. Per interview with the RN manager on 8/26/14 at 12:45PM, the medication delegated caregiver did not check the label of the medicine cup before administering the medications to resident #1. The resident was hospitalized and then transferred to a nursing home for continued rehabilitation.

2. Resident #7 was administered the following medications at 5:45PM on 8/25/14, Mycophenolic acid 200mg by mouth (po), Rifaximin 550mg po, Tacrolimus 2mg po. Topiramate 50mg po and Acyclovir 200mg (two tablets) po. Review of the physician orders in the medical record it was presented that the above medications were to be specifically administered at 4:00PM. This was confirmed by the medication delegated caregiver

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R155	Continued From page 3	R155	See Attached	

and the RN manager at 6:00PM.

3. Resident #8 on 8/25/14 at 5:00PM was given his/her Humalog self injectable, pre-filled insulin syringe at 5:00PM at which time h/she administered. Per medical record review, the Humalog is to be given with meals, which was not served until 45 minutes after the insulin was administered. Per manufacturer's (Lily)guidelines dosage is to be given as follows: DOSAGE AND ADMINISTRATION The dosage of HUMALOG must be individualized. Subcutaneous Injection: Administer within 15 minutes before a meal or immediately after a meal. Per delegated medication caregiver and RN manager at 6:00PM, confirmation was given that the medication was not given at the correct time

4. During observation of the evening medication administration, scheduled for 5:30PM, the delegated medication caregiver did not adhere to the basic 5 rights of medication administration for the 8 residents observed. H/she pre-poured medications by checking the medication administration record against the label on the medication bottles and placed the medications into plastic medicine cups that had the name of the resident clearly labeled. When h/she administered the medications to the residents h/she spoke the resident name and without checking the name on the medicine cup, h/she gave the medicine to the resident. After administration of medicines were complete, h/she confirmed that h/she looks at the pills in the cup and knows who the resident is. Per interview with the RN manager at 6:00PM, h/she confirmed that the incident with Resident #1 had occurred because the completion of the process for checking for the right patient was not followed and that the caregiver had just identified by the

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R155	Continued From page 4 pills in the cup. 5. During record review for Resident #6 on 8/26/14 at 11:15AM, it was found that a physician order signed and dated on 7/31/14 by the attending psychiatrist was to decrease Haldol via intramuscular (IM) injection of 0.75 ml from weekly dosing to being administered every 10 days. The primary care physician reviewed and signed the current medication list on 8/1/14, which reflected to give the Haldol injection weekly. The August Medication Administration Record (MAR) presents the Haldol to be given every 10 days. The medication was administered on an every 10 day basis per the psychiatrist order. Per interview with the RN manager at this time, h/she confirmed that the psychiatrist had seen Resident #6 and gave the order to decrease the Haldol from every week to every 10 days. H/she also confirmed that the primary physician had signed the current list of medications to reflect that the Haldol was to be given every week and that even though the psychiatrist orders the antipsychotic and psychotropic medications for Resident #6, the primary care physician is the one that approves all orders. H/she stated that h/she had transcribed the order from the psychiatrist to the MAR that was all ready in the medication administration record, but had not made the change on the orders to be reviewed by the primary care physician.	R155	See Attached	
R160 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.a Each residential care home must have written policies and procedures describing the	R160	See Attached	

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R160	Continued From page 5 home's medication management practices. The policies must cover at least the following: (1) Level III homes must provide medication management under the supervision of a licensed nurse. Level IV homes must determine whether the home is capable of and willing to provide assistance with medications and/or administration of medications as provided under these regulations. Residents must be fully informed of the home's policy prior to admission. (2) Who provides the professional nursing delegation if the home administers medications to residents unable to self-administer and how the process of delegation is to be carried out in the home. (3) Qualifications of the staff who will be managing medications or administering medications and the home's process for nursing supervision of the staff. (4) How medications shall be obtained for residents including choices of pharmacies. (5) Procedures for documentation of medication administration. (6) Procedures for disposing of outdated or unused medication, including designation of a person or persons with responsibility for disposal. (7) Procedures for monitoring side effects of psychoactive medications. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to effectively develop a procedure for monitoring side effects of psychoactive medications for 2 out of 6 records reviewed in the sample. Findings include: 1. Per medical record review on 8/26/14 at 12:00PM, Resident #3 receives psychoactive	R160	See Attached	

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R160	Continued From page 6 medication and there is no evidence of AIMS/DISCUS or other type of monitoring for side effects for the usage of Seroquel 25mg four times daily. Per interview with the Registered Nurse manager, at this time h/she confirmed that the resident is followed by United Counseling Service (UCS) and they perform the AIMS test for their clients. H/she further stated that UCS keeps the test and they do not provide the facility with a copy for the medical record. 2. Record review for Resident #6 on 8/26/14 at 11:15AM presented with the resident receiving Haldol 5 mg twice a day for agitation and Ativan 0.5mg three times a day as needed. There is no evidence that any type of monitoring for side effects for the usage of psychoactive medication. Per confirmation with the RN at this time, h/she stated that the resident is followed by United Counseling Service (UCS) and they perform the AIMS test for their clients. H/she further stated that UCS keeps the test and they do not provide the facility with a copy for the medical record.	R160	See Attached	
R162 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.c. Staff will not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's written, signed order and supporting diagnosis or problem statement in the resident's record. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure that staff not assist with or	R162	See Attached	

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R162	Continued From page 7 administer any medication, prescription or over-the-counter medications for which there is not a physician's written, signed order and supporting diagnosis or problem statement in the resident's record for 2 of 8 residents, #4 and #5, in the sample. Findings include: 1. On 8/25/14 at 5:30PM, during review of medical records following medication administration, the medication administration record (MAR) presented that Resident #4 was to receive Acidophilus/Pectin one by mouth (PO) at 5:00PM and Cephalexin 500mg PO four times a day with the dose being administered to be given with meal. It was administered at 5:45PM and dinner was served at 5:30PM. When the medical record for Resident #4 was conducted, it was found that there was no evidence of a signed physician order for either of the medications. The manager presented a faxed communication from the pharmacy that indicated they had received the order from the physician. The manager confirmed on 8/25/14 at 5:50PM that there was no evidence of a signed physician order for the above administered medications and that it was the practice of the facility to accept the pharmacy communication for the medications. 2. On 8/25/14 at 5:30PM, during review of medical records following medication administration, the medication administration record (MAR) presented that Resident #5 was to receive Lactase Enzyme 3000Units, two tablets, PO at 5:00PM and Metformin XR 500mg PO at 5:00PM. When the medical record for Resident #5 was reviewed, it was found that there was no evidence of a signed physician order for either of the medications. The manager presented a faxed communication from the pharmacy that indicated they had received the order from the	R162	See Attached	

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R162	Continued From page 8 physician. The manager confirmed on 8/25/14 at 5:50PM that there was no evidence of a signed physician order for the above administered medications and that it was the practice of the facility to accept the pharmacy communication for the medications.	R162	See Attached	
R165 SS=G	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (3) The registered nurse must accept responsibility for the proper administration of medications, and is responsible for: i. Teaching designated staff proper techniques for medication administration and providing appropriate information about the resident's condition, relevant medications, and potential side effects; ii. Establishing a process for routine communication with designated staff about the resident's condition and the effect of medications, as well as changes in medications; iii. Assessing the resident's condition and the need for any changes in medications; and Monitoring and evaluating the designated staff performance in carrying out the nurse's instructions. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure that unlicensed staff properly administer medications and failed to assure the registered nurse was monitoring and	R165	See Attached	

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R165	Continued From page 9 evaluating the designated staff performance in carrying out the nurse's instructions in medication administration for 4 residents (Residents #1, #6, #7 and #8) The findings include: 1. During observation of the evening medication administration on 8/25/14, between 5:00 and 5:45PM, the delegated medication staff administered 20 medications. H/she began the administration of the pre-poured medications at 5:00PM. During this time it was observed that h/she did not check the label that had the name of the resident on the plastic medication cup that held the resident's medication prior to administering the medications. H/she did not ask the resident's name, but stated to this surveyor who the resident was. The staff member confirmed after the administration pass was complete that h/she does not look at the name and stated that "I know the medications that they get." During interview with the registered nurse manager on 8/26/14 at 12:45PM, h/she confirmed that they were aware that the delegated medication staff member did not check the resident name on the label, but looked to see what the pills were in the medication cup and that is "why h/she gave the wrong medications to Resident #1 and why h/she is in the hospital." Per the RN, there has been no further training at this time and that monitoring and observation of a medication administration occurs only after the initial training. 2. Resident #1 was administered medications that were for another resident on 8/19/14 during the evening scheduled 5:30PM medication administration time. The medications included Clonazapine 200mg and Risperidone 2mg. Resident #1 did not have an order for psychotropic medications. His/her diagnoses	R165	See Attached	

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R165	Continued From page 10	R165	See Attached	

include: Developmental Delay, Hypertension, Diabetes Type 2 and Hypercholesterolemia. During interview with medication delegated caregiver at 6:15PM on 8/25/14, h/she stated that it got very chaotic and it was noisy and there was a lot of confusion. H/she stated that "a whole bunch of residents" came into the kitchen at the same time to get there medications and h/she just started giving them. H/she stated that they gave the medications and then when they looked into the medicine cup for the resident that was next, h/she realized that the wrong medication had been given to Resident #1 and h/she got immediate emergency assistance. H/she also realized that the label should have been checked and h/she should not have relied on what the pills looked like. Per interview with the RN manager on 8/26/14 at 12:45PM, the medication delegated caregiver did not check the label of the medicine cup before administering the medications to resident #1. The resident was hospitalized and then transferred to a nursing home for continued rehabilitation.

3. Resident #7 was administered the following medications at 5:45PM on 8/25/14, Mycophenolic acid 200mg by mouth (po), Rifaximin 550mg po, Tacrolimus 2mg po, Topiramate 50mg po and Acyclovir 200mg (two tablets) po. Review of the physician orders in the medical record it was presented that the above medications were to be specifically administered at 4:00PM. This was confirmed by the medication delegated caregiver and the RN manager at 6:00PM.

4. Resident #8 on 8/25/14 at 5:00PM was given his/her Humalog self injectable, pre-filled insulin syringe at 5:00PM at which time h/she administered. Per medical record review, the Humalog is to be given with meals, which was not

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R165	Continued From page 11 served until 45 minutes after the insulin was administered. Per manufacturer's (Lily)guidelines dosage is to be given as follows: DOSAGE AND ADMINISTRATION The dosage of HUMALOG must be individualized. Subcutaneous Injection: Administer within 15 minutes before a meal or immediately after a meal. Per delegated medication caregiver and RN manager at 6:00PM, confirmation was given that the medication was not given at the correct time 5. During observation of the evening medication administration, scheduled for 5:30PM, the delegated medication caregiver did not adhere to the basic 5 rights of medication administration for the 8 residents observed. H/she pre-poured medications by checking the medication administration record against the label on the medication bottles and placed the medications into plastic medicine cups that had the name of the resident clearly labeled. When h/she administered the medications to the residents h/she spoke the resident name and without checking the name on the medicine cup, h/she gave the medicine to the resident. After administration of medicines were complete, h/she confirmed that h/she looks at the pills in the cup and knows who the resident is. Per interview with the RN manager at 6:00PM, h/she confirmed that the incident with Resident #1 had occurred because the completion of the process for checking for the right patient was not followed and that the caregiver had just identified by the pills in the cup. 6. During record review for Resident #6 on 8/26/14 at 11:15AM, it was found that a physician order signed and dated on 7/31/14 by the attending psychiatrist was to decrease Haldol via intramuscular (IM) injection of 0.75 ml from	R165	See Attached	

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R165	Continued From page 12 weekly dosing to being administered every 10 days. The primary care physician reviewed and signed the current medication list on 8/1/14, which reflected to give the Haldol injection weekly. The August Medication Administration Record (MAR) presents the Haldol to be given every 10 days. The medication was administered on an every 10 day basis per the psychiatrist order. Per interview with the RN manager at this time, h/she confirmed that the psychiatrist had seen Resident #6 and gave the order to decrease the Haldol from every week to every 10 days. H/she also confirmed that the primary physician had signed the current list of medications to reflect that the Haldol was to be given every week and that even though the psychiatrist orders the antipsychotic and psychotropic medications for Resident #6, the primary care physician is the one that approves all orders. H/she stated that h/she had transcribed the order from the psychiatrist to the MAR that was all ready in the medication administration record, but had not made the change on the orders to be reviewed by the primary care physician.	R165	See Attached	
R179 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following:	R179	See Attached	

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R179	Continued From page 13 (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that State regulated training was provided to 4 of 5 employees reviewed before providing any direct care to residents. Findings include: 1. Two employees, one that was hired 7/18/14 and another that was hired in June of 2014 have received no training in any of the seven required areas. Confirmation was made by the registered nurse manager on 8/26/14 at 10:15AM that the facility does not have an orientation packet and training is only done on a yearly basis and the employees do not receive the training until the training is offered. 2. Two of the employees, one hired 2/28/14 and one hired 3/26/14 have not received training in the areas of Resident Rights, Fire Safety and Infection Control. Confirmation was made by the registered nurse manager on 8/26/14 at 10:15AM that the facility does not have an orientation	R179	See Attached	

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R179	Continued From page 14 packet and training is only done on a yearly basis and the employees do not receive the training until the training is offered.	R179	See Attached	
R181 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.d The licensee shall not have on staff a person who has had a charge of abuse, neglect or exploitation substantiated against him or her, as defined in 33 V.S.A. Chapters 49 and 69, or one who has been convicted of an offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to the public welfare, in any jurisdiction whether within or outside of the State of Vermont. This provision shall apply to the manager of the home as well, regardless of whether the manager is the licensee or not. The licensee shall take all reasonable steps to comply with this requirement, including, but not limited to, obtaining and checking personal and work references and contacting the Division of Licensing and Protection in accordance with 33 V.S.A. §6911 to see if prospective employees are on the abuse registry or have a record of convictions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility has on staff an employee that has had a charge of simple assault. Findings include: Per review of 5 employee files, one of the employees was hired in June of 2014. H/she consented to having background checks, which included criminal records. The results returned to	R181	See Attached	

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R181	Continued From page 15 the facility presented that the resident has a charge of simple assault. The record also presents that the employee filed a motion with the courts 6/4/14 to have his/her record expunged. The courts responded with a document that stated that the State had 10 days to respond to the request and if no response was presented, the court would come to a decision without a hearing. There is no evidence of the results of the court decision. Per interview with the registered nurse manager at 5:10PM on 8/25/14, h/she said that h/she had thought the document in the file was had expunged the employee of the assault charges and confirmed that there is no evidence of that. H/she further confirmed that a waiver was not requested from the State Agent for this employee.	R181	See Attached	
R192 SS=C	V. RESIDENT CARE AND HOME SERVICES 5.12 Records/Reports 5.12.d Reports and records shall be filed and stored in an orderly manner so that they are readily available for reference. Resident records shall be kept on file at least seven (7) years after the date of either the discharge or death of the resident. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain medical records in an orderly manner so they are readily available for reference. Findings include: 1. Two residents, Resident #5 and Resident #6, did not have physician orders available in the	R192	See Attached	

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R192	Continued From page 16 medical record as discovered during medication reconciliation on 8/25/14 at 5:50 PM. The registered nurse (RN) manager confirmed at this time that the orders were not yet filed and h/she had to look for them. 2. Of the 6 records reviewed in the sample, the admission agreements were not in the medical record for all 6, but were kept in a separate file folder in the office. This was confirmed by the RN on 8/25/14. 3. The 6 medical records reviewed were in disarray and papers were falling out of the binders. One of the caregivers had made a comment regarding the difficulty they have in confirming physician orders and that the "charts are a mess". Review with the RN regarding the medical records resulted in, "I know." 4. A signed financial agreement for Resident # 9 was not in the medical record and the RN stated during interview that h/she has a payee representative outside of the facility, but the facility holds some money for him in the safe. Document regarding financial agreement is kept in the office and not readily available	R192	See Attached	
R208 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.c Incidents involving resident-to-resident abuse must be reported to the licensing agency if a resident alleges abuse, sexual abuse, or if an injury requiring physician intervention results, or if there is a pattern of abusive behavior. All resident-to-resident incidents, even minor ones,	R208	See Attached	

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R208	Continued From page 17 must be recorded in the resident's record. Families or legal representatives must be notified and a plan must be developed to deal with the behaviors This REQUIREMENT is not met as evidenced by: Based on staff interview and a review of reports kept by the facility, the facility failed to report an incident involving resident to resident abuse for 2 residents, Resident #2 and #3. Findings include: During an investigation of a reported complaint on 8/26/14 at 11:55 AM, it was discovered that the facility did not have evidence regarding reporting of an incident between Resident #2 and #3 on 7/14/14. The registered nurse (RN) manager provided me with one page of a facility incident reporting form, but was unable to provide evidence that it was sent to the State Agent as required by Vermont State Regulations. The RN stated that h/she had sent the report, but did not have evidence to that fact. Per text message to the State Agent on 8/26/14 at 1:17 PM in regards to the incident, it was not reported by the facility but it was reported by an outside source, 11 days after the incident had occurred at the facility. The nurse manager confirmed that there have been problems in reporting in the past and the owner stated that they do not have a system in place for having evidence of reports being made to the State Agent. In review of the medical records for Resident #2 and #3, there is no evidence of a developed plan for dealing with the behaviors that were exhibited. In review of the incident on 7/14/14, Resident #2 kicked Resident #3 after Resident #3 attempted to intervene on behalf of Resident #9. Resident	R208	See Attached	

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R208	Continued From page 18 #2 also swung at and hit Resident #2, striking him/her in the face. Resident #3 presented with bruises to upper right thigh and a cut to a finger on the left hand. Staff intervention occurred after another resident informed them of the altercation, which occurred on the front porch.	R208	See Attached	
R224 SS=D	VI. RESIDENTS' RIGHTS 6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review, the facility failed to ensure that 1 resident, Resident #2 was free from physical abuse. Findings include the following: Resident #2 and #3 were victims of physical abuse on 7/14/14 when both residents got into an altercation that resulted in kicking and punching each other. Resident #2 stated on 8/26/14 at 11:55 PM that h/she had intervened on behalf of another resident that h/she felt was being treated rudely by Resident #3. During the intervention, Resident #3 kicked him in the right leg. At this time Resident #2 stated that h/she began to swing punches and h/she struck Resident #3 in the face. Interview with Resident #3 on 8/26/14 at 12:30 PM presented with him/her recalling that "One guy was coming after me and I know karate and everything." He indicated that h/she kicked out, but did not recall if contact was made, but h/she remembered that, h/she was hit in the	R224	See Attached	

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R224	Continued From page 19 mouth and "I hit him back". Per interview with the registered nurse, h/she indicated that staff intervened at the time of the incident and the two were separated. The owner in an interview stated that h/she felt that the incident occurred because Resident #3 was trying to get around Resident #2 and another resident and may have pushed one of the chairs they were sitting in and that set off the series of events. Per nurse manager, Resident #3 used to have a short fuse until h/she was started on Seroquel and h/she has been great since then.	R224	See Attached	
R240 SS=F	VII. NUTRITION AND FOOD SERVICES 7.1 Food Services 7.1.b Meal Patterns The following guide provides the basis for meal planning and will provide nearly 100% of the RDA for most residents. In cases of a resident's advanced age and very light activity, homes may consider each resident's needs with respect to portion size and frequency of eating but shall not compromise overall nutrient intake. In addition to the suggested food servings, particular emphasis must be given to fluid intake for residents. Food Group / Suggested Daily Servings / What Counts as a Serving Bread, Cereal, Rice, Pasta / 6-11 / 1 slice bread, tortilla, ½ bagel, English Muffin, ½ hamburger/ hot dog roll, pita, ½ cup cooked cereal, rice, pasta	R240	See Attached	

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R240	Continued From page 20 1 oz ready-to-eat cereal 3-4 small or 2 large crackers Fruit 2-4 ¾ cup 100% fruit juice 1 medium apple, banana or other fruit ½ cup fresh, cooked or canned fruit ¼ cup dried fruit Vegetables 3-5 ½ cup cooked or chopped raw vegetables 1 cup leafy, raw vegetables ¾ cup vegetable juice Milk, Yogurt, 3 or more 1 cup milk, yogurt Cheese 1 ½ oz natural cheese Meat, Poultry, 2 (total of 2-3 oz cooked lean Legumes, Eggs 4-5 oz/day) meat, poultry or fish Nuts ½ cup cooked legumes 1 egg 2 tablespoons peanut butter 1/3 cup nuts Fluids 8 cups Water, juice, herbal tea (8 fluid oz each) non-caffeineated Coffee, tea At least one serving of citrus fruit or other fruit or vegetable rich in vitamin C shall be served each day.	R240	See Attached	

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R240	Continued From page 21 At least one serving of fruit or vegetable rich in vitamin A shall be served at least every other day. This REQUIREMENT is not met as evidenced by: Based on review of the menus for the week of the scheduled re-licensing survey of the facility, and staff interview, the facility failed to provide 100% of the recommended dietary allowances. Findings include: The required number of servings for meat or equivalent was not reflected for 2 of 7 days. On 8/27 and 8/29/14 there is only 1 meat or equivalent serving for the day. The minimum required number of servings of fruit were reflected only 3 days for the week. Breakfast was the only time that fruit was being offered on 8/27, 29, 30 and 31. The minimum required number of vegetable servings were reflected for only 3 days for the week, 8/25, 27, 28 and 30 were only reflecting 2 vegetable servings for the day. The minimum servings of breads/cereals/rice/pasta or equivalence were reflected for no days for the week of 8/25 - 8/31/14. 5 servings were reflected for 8/25, 26, 28, 29 and 30. 8/27 had 3 servings and 8/31 shows 4 servings. Per interview with the owner on 8/26/14, h/she stated that they try to meet the requirements and that h/she was responsible for the menu. H/she further stated that they would begin working on correcting the problem immediately.	R240	See Attached	
R246 SS=F	VII. NUTRITION AND FOOD SERVICES	R246		

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R246	Continued From page 22 7.2 Food Safety and Sanitation 7.2.a Each home must procure food from sources that comply with all laws relating to food and food labeling. Food must be safe for human consumption, free of spoilage, filth or other contamination. All milk products served and used in food preparation must be pasteurized. Cans with dents, swelling or leaks shall be rejected and kept separate until returned to the supplier. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that food was properly labeled, safe for human consumption, free of spoilage, filth or other contamination. Findings include: 1. On 8/25/14 at 1:30 PM during a tour of the facility's kitchen and food storage areas, it was discovered that there was a 10# can with no label and two dented cans, one being a 10# can from a supplier and another being a can that was bought at the grocery store. Per interview with caregiver and Registered Nurse (RN) manager at this time, the facility returns dented cans. The caregiver stated that h/she could not be sure if the can was dented when it was bought or because of being dropped. Per RN the can with no label and the 10# dented can should be removed and the dented can set aside to return to the supplier, but confirmed that all 3 of the cans were still in the food storage able and could be used by a staff member. 2. During the kitchen and food storage tour, it was observed that the kitchen refrigerator needed to be cleaned, and per confirmation by the RN, the bottle of 0.9% Sodium Chloride that was located	R246	See Attached	

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R246	Continued From page 23 on the shelf of the refrigerator door should not be in the refrigerator with food. 3. A freezer that is located in the treatment area was observed to have unidentified food in freezer. There were no dates as to when the frozen food was placed in freezer and for some foods the contents were not marked. The freezer needed to be defrosted and there were foods with freezer burns. There was boneless chicken breasts that were placed in the freezer 5/1/2013 and per FoodSafety.gov guidelines Chicken pieces can be frozen up to 9 months. There was a package of sweet sausage wrapped in torn aluminum foil and dated 1/20/14, per FoodSafety.gov sausage can be frozen up to 1 to 2 months. Observed was a loaf of bread, with no date on it as to when placed in freezer, with a torn outer wrapping and ice crystals formed on the crust. There was a patty of assumed meat that was grayish brown in color, that had no label to indicate the content or the length of time it had been in the freezer. Large packages of meat and vegetables and reportedly soups that were purchased from a vendor were in the freezer with no dates as to when first frozen. The RN stated that the rule of first in and first out for food rotation is observed, but h/she could not guarantee that it was accurate because there were no dates on the food. 4. During the tour of the food storage areas and the refrigerators/freezers on 8/25/14, it was observed that the refrigerator in the laundry room had a spoon on a shelf of the door that had a brown substance on it with tongue lick marks present. There was a can of opened chocolate sauce next to it. Per confirmation with caregiver that accompanied me to this area, h/she was not sure what was on the spoon but assumed that it	R246	See Attached	

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FORM APPROVED

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0103	A. BUILDING: ______ B. WING ______	C 08/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON ELMS	126 ELM STREET BENNINGTON, VT 05201

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R246	Continued From page 24	R246	See Attached	

was the chocolate. H/she also confirmed that the spoon had tongue lick marks on it and the refrigerator is clearly marked that only staff is to get into the refrigerator, that residents have access to the refrigerator and will "get into it, that is why the sign."

5. On the second floor is that there is no recordings for temperatures and per the RN, the refrigerator is used for the residents, but there is rarely anything in it. Observed in the refrigerator on 8/25/14 during the tour of the food storage, there were candy bars, a bottle of water and a bottle of Gatorade. The RN confirmed that there were no resident names on the water or the Gatorade and that the refrigerator temperatures are not kept for this refrigerator.

6. In the pantry it was observed that there was an undated open box of rice, chow mein noodles, 6 boxes of cereal, a 10# bag of sugar and a bag of salsa chips. There also was a bottle of all purpose seasoning that was dated with an expiration date of 9/2011. A partially used can of Crisco shortening had a crumpled up paper towel in it. Confirmation was made by the caregiver and the RN at the time of discovery that items opened are not labeled and the seasoning was outdated and the Crisco presents an infection control issue as everyone uses the Crisco and puts their hands into the can to grease pans, etc.

7. Observed on the second and third floor of the facility were pitchers of water, that were warm and without covers to prevent dirt and bugs from getting into the pitchers. The RN stated that the pitchers are filled daily and that they should have a properly fitting covers.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 08/26/2014

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R247	Continued From page 25	R247		
R247 SS=E	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.b All perishable food and drink shall be labeled, dated and held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service. This REQUIREMENT is not met as evidenced by: The facility failed to insure that all perishable food and drink were labeled, dated and held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service. Findings include: During the initial tour of the facility on 8/25/14 at 12 Noon, there was no evidence of temperatures (temps) being taken for hot foods prior to service and during the months of July or August. The refrigerator temps for one of the refrigerators, in the treatment room, were recorded being recorded as 10 degrees, which is below freezing and will cause damage to fruits and vegetables and some dairy products. There were no dated food items in the refrigerators to indicate when anything was open or placed in them. Confirmation was made by the registered nurse manager at the time of discovery on 8/25/14.	R247		
R259 SS=D	VII. NUTRITION AND FOOD SERVICES 7.3 Food Storage and Equipment	R259		

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R259	Continued From page 26	R259		

7.3.i Poisonous compounds (such as cleaning products and insecticides) shall be labeled for easy identification and shall not be stored in the food storage area unless they are stored in a separate, locked compartment within the food storage area.

This REQUIREMENT is not met as evidenced by:
Based on observation, resident and staff interview, the facility failed to store a poisonous compounds (such as cleaning products) away from a food preparation and storage area unless they are stored in a separate, locked compartment within the food storage area.
Findings include:

1. During initial tour of facility on 8/25/14 it was observed that a closet in the kitchen that had cleaning supplies and chemicals was not locked. The RN manager stated that it is usually always locked. Per interview with the owner early in the afternoon, h/she confirmed that it was not locked because the lock had broken and h/she was waiting to have it repaired. On 8/26/14, the closet was still without a lock and the owner stated that someone would be in today to repair, but confirmed that it was not yet repaired.

2. During Interview with Resident #6 on 8/26/14 at 11:15AM, h/she stated that a couple of months ago there was a spray bottle on the kitchen counter that contained window spray. H/she stated that they were upset with one of the staff members because h/she thought they had gotten the wrong medicine and that the staff member was trying to poison him/her. Resident #6 stated that h/she sprayed the cleaner into the opening of a can of "MONSTER" drink and on the top of the

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R259	Continued From page 27 can. Resident #6 stated that h/she probably would not have done that if the spray had not been there.	R259		
R266 SS=F	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, the facility failed to provide and maintain a safe, functional, sanitary, homelike and comfortable environment. Findings include: 1. During initial tour of facility on 8/25/14 it was observed that a closet in the kitchen that had cleaning supplies and chemicals was not locked. The RN manager stated that it is usually always locked. Per interview with the owner early in the afternoon, h/she confirmed that it was not locked because the lock had broken and h/she was waiting to have it repaired. During interview with Resident #6 on 8/26/14 at 11:15AM, h/she stated that a couple of months ago there was a spray bottle on the kitchen counter that contained window spray. H/she stated that they were upset with one of the staff members because h/she thought they had gotten the wrong medicine and that the staff member was trying to poison him/her. Resident #6 stated that h/she sprayed the cleaner into the opening of a can of "MONSTER" drink and on the top of the can. Resident #6 stated that h/she probably would not	R266		

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R266	Continued From page 28 have done that if the spray had not been there. On 8/26/14, the closet was still without a lock and the owner stated that someone would be in today to repair, but confirmed that it was not yet repaired. 2. The shower in room #4 was found to be rusted and the base was peeling from the wall of the shower, there was a sharp edge in the crevice. This was confirmed by the RN manager. 3. During the initial tour stair railings on the back stair case near the bottom of the stairs and the top railing on the front stair case were loose. The top rail going to the third floor. This was confirmed by the RN manager. 4. Per observation Room #2, bed #4, there was a gouge in the flooring that this surveyor caught their toe in. Upon closer examination it was found that there were several pieces of the wood that could cause a resident to get slivers if walked on. There were also 2 unsecured oxygen tanks on the dresser for the resident in bed #2, the resident told the manager they were broken and needed to be returned. The bath mat is ripped in the bathtub and there is soap scum build up on the floor and sides of the tub for Room #2. Confirmed at the time of discovery by the RN that accompanied me on the tour. 5. It was observed that the shower in Room #3 had the shower mat and floor of the shower had black mold. Confirmed by the RN manager at time of discovery. 6. Room #8 presented with a strong odor of urine and the RN manager stated that it is always like that because the resident that lives there is incontinent and has "kidney problems" I asked	R266		

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R266	Continued From page 29 what they do to prevent the odor and h/she stated that they use odor eliminators and h/she will personally purchase them and they have tried everything. 7. Other observations were that the hallway near room #5 had a crack outside the door way that encompassed a large part of the wall. Linen in the linen closet, consisting of sheets and bedspreads were balled up and on the floor. The fireplaces in the sitting room and the dining room had missing tiles on the front and the floor. 8. Observed during the initial tour in the treatment room there were covered opaque plastic containers that contained nebulizer respiratory equipment. The inside of the containers, where oxygen tubing and nebulizer mouthpieces were stored, were dirty and some had dead bugs in them. Confirmation made by the RN at the time of discovery. Also found in the treatment room was a plastic open container that contained wound dressing supplies and a bottle of Iodine and a bottle of antiseptic cleanser. The RN confirmed that the Iodine and cleanser were no longer being used and should be discarded. H/she also confirmed that the area was accessible to the residents and the container with the Iodine and antiseptic cleanser could be taken by a resident because it was easily reachable and not secured.	R266		
R269 SS=A	IX. PHYSICAL PLANT 9.2 Residents' Rooms 9.2.b Rooms shall be of dimensions that allow for the potential of not less than three (3) feet	R269		

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R269	Continued From page 30 between beds and three feet between the bed and the side wall to facilitate cleaning and easy access. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that all rooms were allowing for the potential of not less than three (3) feet between beds and three feet between the bed and the side wall to facilitate cleaning and easy access. During the initial facility tour on 8/25/14 at 12 Noon, it was observed that in Room #2 there is less than 3 feet between beds number 3 and 4. Confirmation made by the registered Nurse manager that accompanied this surveyor on the tour.	R269		

Plan of Correction

Washington Elms

9/15/14

R145

With regards to findings #1, #2 and #3; care plans have been updated as of 8/27/14. Resident assessment due date form was developed and implemented on 8/27/14 to ensure care plans will be updated when assessments are complete. This form will be updated by RN on the 1st of every month and upon change in condition. Care plan will be reviewed at every assessment date and beginning of every month to ensure they are updated with change in condition, annually and current.

R155

Finding 1: 6 rights of medication administration was reviewed with all medication delegated staff 8/29/14. Going forward 2000 medication administration process has been changed. Staff member B stands at kitchen door and allows only two residents at a time into kitchen. Staff member A gives the first resident their medication and a snack, 2nd resident does not get medication and snack until first resident has completed taking their medication. Staff and resident must read label on medication cup prior to administration of medications. Staff member A in this incident has been taken off medication delegation duties until a retraining process is complete which started 9/14/14.

All medication delegated staff have been retrained in medication delegation by 9/15/14 . Medication delegated staff will be monitored and audited by RN every 3 months and as needed.

Finding 2: Contacted MD and pharmacy and medication time has been changed to coincide with other medication due times.

Finding 3: Staff has been educated on giving insulin only just prior to meal being served on 8/27/14. Diabetic inservice will be held on 9/29/14 to review with staff diabetes disease process, effect and purpose of insulin and best practice for administering insulin. Medication delegated staff member will document time of insulin administration. RN will review this on a weekly basis to ensure all staff is administering insulin at appropriate time.

Finding 4: 6 rights of medication administration was reviewed with all medication delegated staff 8/29/14. Staff and resident must read label on medication cup prior to administration of medications.

Finding 5: Night before resident is to go to MD appointment the night staff member will check current MAR and be sure a copy of the updated current MAR is sent with resident to MD appointment for MD review. Day shift staff member will 2nd check the MAR to be sure it is current prior to resident MD appointment. This completed 8/29/14.

R160

Findings 1 & 2: AIMS testing to monitor side effects of all physchotropic medication is done at United Counseling Service, (UCS-Psychiatric Service Provider) will provide Washington Elms a copy of the residents AIMS test results for the resident chart. Release of information forms have been obtained and will be completed and faxed to UCS to obtain current AIMS test results on all residents currently receiving psychotic medications completed 9/16/14.

R162

Finding 1 & 2: All electronic orders will be taken and monitored by the RN. RN has faxed copy of electronic order to physician for review and signature, completed 8/29/14. All future electronic orders will be faxed by RN to physician to be signed within 24 hours of receiving them on weekdays.

R165

Findings 1 through 6: 6 rights of medication administration was reviewed with all medication delegated staff 8/29/14. Staff and resident must read label on medication cup prior to administration of medications. 2000 medication administration process has been changed. Staff member B stands at kitchen door and allows only two residents at a time into kitchen. Staff member A gives the first resident their medication and a snack, 2nd resident does not get medication and snack until first resident has completed taking their medication. Contacted MD and pharmacy and medication time has been changed to coincide with other medication due times. Staff has been educated on giving insulin only just prior to meal being served on 8/27/14. Diabetic

inservice will be held on 9/29/14 to review with staff diabetes disease process, effect and purpose of insulin and best practice for administering insulin. Medication delegated staff member will document time of insulin administration. RN will review this on a weekly basis to ensure all staff is administering insulin at appropriate time.

Finding 6: New order obtained as of 8/29/14 for haldol IM 0.75ml to be administered every 10 days. Night before resident is to go to MD appointment the night staff member will check current MAR and be sure a copy of the updated current MAR is sent with resident to MD appointment for MD review. Day shift staff member will 2nd check the MAR to be sure it is current prior to resident MD appointment. This completed 8/29/14.

R179

Finding 1: All new staff has been trained on HIPPA, Resident Rights and Abuse, Neglect and Exploitation on 9/9/14.

Finding 2: Packet of mandatory inservice handouts with self test, which includes State required training ,to be completed by new staff has been developed and are scheduled to be completed 9/19/14. In the future these packets with be given by RN upon hire and must be complete prior to first shift with residents.

R181

Finding: Staff person with incomplete file related to simple assault charge on criminal background check has obtained and given RN copies of court decision for expungement to be granted 6/24/14. Copies on

file as of 9/15/14. Going forward if background check requires waiver, waiver will be obtained prior to hire.

R192

Finding 1: RN will take care of orders and filing them in appropriate place in chart within 24 hours of receiveing them on business days. This was completed 8/27/14. Order in question in this example was received the evening before the survey.

Finding 2: Money and Valuable Sheet (financial agreement) will be placed in the resident chart by 9/20/14.

Finding 3: New larger charts are being implemented, charts will be reviewed and set up in orderly fashion with hole punches that are torn repaired and completed 9/19/14.

Finding 4: Money and Valuable Sheet (financial agreement) for resident in question placed in resident chart on 8/27/14.

R208

Finding : RN will follow up with complaints made to the State of Vermont for incidents involving abuse, neglect or exploitation with a phone call within 24 hours on business days to check that the State has received the report. Name of the State employee the RN speaks to on the phone will be documented in the resident chart in note section as of 9/15/14. There was no behavior plan for this resident as this was the first incident, there was no behaviors prior to this. When this incident

happened MD changed medications immediately and there has been no further incident. Incident in question occurred 7/14/14.

R224

Duplicate - See next page

Finding: Walkway on the porch where incident occurred has been widened by moving chairs and rockers back giving more space for residents to move without walking into other residents causing residents to become defensive. This was completed 7/14/14. The resident in question had a medication change on 7/14/14 with no further incidents of this behavior noted.

R240

Finding: Owner creates menus. As of 8/27/14 owner is using the guide supplied by State with servings of each item that is to be given for meals when preparing menu to ensure no serving of any food item is missing out of menu.

R246

Finding 1: All cans have been examined and dented cans were thrown away on 8/25/14. Staff was also educated on 8/25/14 on returning dent can items upon opening cases.

Finding 2: Normal saline located in refrigerator was disposed in garbage, going forward a lock box will be purchased and utilized for any treatment items by 9/23/14.

R224

Finding: Walkway on the porch where incident occurred has been widened by moving chairs and rockers back giving more space for residents to move without walking into other residents causing residents to become defensive. This was completed 7/14/14. The resident in question had a medication change on 7/14/14 with no further incidents of this behavior noted.

R240

Finding: Owner creates menus. As of 8/27/14 owner is using the guide supplied by State with servings of each item that is to be given for meals when preparing menu to ensure no serving of any food item is missing out of menu.

R246

Finding 1: All cans have been examined and dented cans were thrown away on 8/25/14. Staff was also educated on 8/25/14 on returning dent can items upon opening cases.

Finding 2: Normal saline located in refrigerator was disposed in garbage, going forward a lock box will be purchased and utilized for any treatment items by 9/23/14.

Finding 3: All outdated frozen items were disposed of with freezer defrosted on 8/25/14. All food items will be dated upon purchase and staff educated on the rule of 1st in and 1st out when removing food items for use. This was completed 8/25/14.

Finding 4: Refrigerator is to be checked on a daily basis by third shift staff with temperature reading obtained and recorded on temperature

log sheet. New temperature log sheet will also have box for check food date box to be checked. Completion of this will be 9/24/14.

Finding 5: Temperature solution utilized from finding 4 above. All food items will be labeled with resident name if it is personal to resident. Completed 8/25/14.

Finding 6: All undated food items were thrown away 8/27/14. As of 8/25/14, all food items are dated with time of opening. Food label recommendations will be followed regarding care and expiration of item starting 8/25/14.

Finding 7: New water pitchers were purchased and began to be utilized on 8/25/14.

R247

Finding: Food thermometer was purchased and utilized as of 8/25/14 for checking food temperature prior to serving. All staff have been trained in this process to ensure food items are served at correct temperature. All perishable food items will be dated upon purchase completed 8/25/14.

R259

Finding 1: Lock was purchased an applied to cleaning closet on 8/26/14.

Finding 2: Cleaning solutions will be stored in cleaning closet with lock. Staff educated on keeping cleaning closet locked when not in use. Completed 8/27/14.

R266

Finding 1: Lock was purchased an applied to cleaning closet on 8/26/14.

Finding 2: Shower in room for will be replaced by 10/18/14.

Finding 3: Stair railing will be repaired by 9/26/14.

Finding 4: The gouge in floor will be filled with wood glue and a carpet placed by 9/26/14. The 2 unsecured oxygen tanks were returned to Keene Medical for repairs. Bath mat replaced and soap scum build up on floor and tub removed in bedroom 2 – completed 8/27/14. Staff re-educated on cleaning of bathroom items and to alert RN to any issues they discover during personal care of residents that need further assessment or repair – completed 8/27/14.

Finding 5: Room 3 shower mat replaced and shower cleaned and disinfected on 8/27/14. Staff re-educated on cleaning of bathroom items and to alert RN to any issues they discover during personal care of residents that need further assessment or repair – completed 8/27/14.

Finding 6: Room 8 plastic mattress cover replaced on 8/27/14. Bedding continues to be washed separately daily. Commode in room 8 to be cleaned and disinfected every shift – complete 8/27/14. Resident room 8 cleaned and disinfected twice a week and as needed to decrease urine odor – complete 8/27/14.

Finding 7: Room #5 will be spackled and painted by 9/26/14. Housekeeper has been assigned and educated on cleaning and organizing the linen closet every Monday – completed 8/27/14.

Finding 8: All nebulizer machines and containers they are stored in when not in use cleaned 8/27/14. New tubing placed 8/27/14. As of 8/27/14 new process which staff has been trained on is as follows:

On the 1st and 15th of every month the staff member designated as staff B will clean the nebulizer machines and the boxes they are stored in as well as replacing tubing with new tubing.

Iodine disposed of immediately 8/27/14. Future iodine will be kept in locked medicine cabinet in medication room.

R269

Finding: Beds were measured and moved in room #2 so they are at least 3 feet apart. Housekeeper instructed and educated on measuring distance between beds every Wednesday to ensure beds are correct distance apart – completed 8/25/14.